		AND HUMAN SERVICES					TED; 02/18/201 DRM APPROVEI NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IULTIPI ILDING	LE CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		155136	B. WIN	NG			C 02/14/2011
	ROVIDER OR SUPPLIER	UNTAINVIEW TERRACE		190	ET ADDRESS, CITY, STATE, ZIP 00 ANDREW AVENUE 1. PORTE, IN 46350	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÓ PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION E OATE
F 000	INITIAL COMMEN	rs	F	000			
	This visit was for in IN00084888.	vestigation of complaint			•		
and a	Complaint iN00084 federal/state deficie allegations are cited						
	Survey dates: Feb	ruary 10 and 14, 2011					
	Facility number: Provider number: AIM number:	000061 155136 100288620					
the	Surveyor: Mary An	ne Cilella, RN					
3/19/1	Census bed type: SNF/NF: 148 Total: 148						
	Census payor type: Medicare: 16 Medicaid: 114 Other: 18 Total: 148	-	,				
	Sample: 5						
		iencies also reflect state nce with 410 IAC 16.2.					
	Quality review comp Bartelt, RN.	pleted 2/15/11 by Jennie					
F 282 SS=D	483,20(k)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED ARE PLAN	F 2	282			-
	must be provided by	ed or arranged by the facility y qualified persons in ch resident's written plan of					
ABORATOR	CONFECTOR'S ORPROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE	March	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited an approved plan of correction is requisite to continued program participation

Facility ID 000061

PRINTED: 02/18/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING С 8 WING 155136 02/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVENUE **GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE LA PORTE, IN 46350** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 F 282 Continued From page 1 care. This REQUIREMENT is not met as evidenced F 282 by: Based on observation, interviews and record reviews, the facility failed to follow physician's Step One: orders and the plan of care related to the 3/16/2011 Applied the personal alarm for placement of a personal alarm to alert the staff Resident E per the plan of care. for 1 of 3 residents who had fallen in the sample The CNA assigned to the of 5. resident's care was re-educated Resident: E regarding alarm application. Findings include: Step Two: Interview on 2/14/11 at 9:30 a.m., with the All residents with current Assistant Director of Nursing (ADON) indicated alarm utilization were visually Resident E had fallen over the weekend and had inspected to ensure appropriate been sent to the hospital for evaluation. placement of alarms. No Observation on 2/14/11 at 10:00 a.m., indicated deficiencies were noted. Resident E was seated in a wheelchair across from the nurses' station. The left side of the Step Three: resident's forehead was bandaged, a dark All Nursing Staff were rediscoloration was noted under her left eye, and educated regarding alarm steri- strips were noted behind her left ear. Her left wrist was also covered with a bandage. A utilization and appropriate chair alarm was in place. placement per plan of care. DNS and/or designee will Review of the clinical record of Resident E on conduct visual observations of 2/14/11 at 10:45 a.m., indicated the diagnoses alarm placement on 5 random included, but were not limited to depressive disorder, lack of coordination, anorexia and Committee for 180 days.

Random abbits will occur

CLY055 all Shifts and residents daily and report any abnormal involuntary movements. The resident

had orders signed by the physician with an original date of 6/18/10, for a personal alarm to bed with safety clip and check every shift and a personal alarm to wheelchair, activate every shift, DEPARTMENT OF HEALTH AND HUMAN SERVICES DO FOR MEDICARE & MEDICARD SERVICES

PRINTED, 02/18/2011 FORM APPROVED OMB NO 0938-0391

CENTERS	FUR MEDICAL	C & MEDICAID SERVICES			OND NO	<u>7. 0336-038 I</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(XZ) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATÉ SURVEY COMPLETED	
		155136	B MII	NG	02/14/20	
	VIDER OR SUPPLIE	COUNTAINVIEW TERRACE		STREET ADDRESS, CITY, STATE, ZIP 1900 ANDREW AVENUE LA PORTE, IN 46350	CODE	_
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTION TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
F 282 C	ontinued From I	nage 2	E '	282		

Continued From page 2

The quarterly minimum data set (MDS) assessment, dated 11/18/10, indicated the resident required assistance in all areas of daily living. She was coded as not being steady in moving from a seated to standing position, walking, turning around and moving on and off the toilet.

The fall risk assessment dated 12/19/10, indicated the score was 10. A total score of 10 or above deemed the resident at risk for falls.

The plan of care dated 6/10/10, identified the resident to be at risk for falls related to decreased mobility. The approaches included, but were not limited to: nonskid strips on floor next to bed, personal alarm to bed with safety snap, personal alarm to wheel chair with safety snap and foam mattress with contoured edges.

The CNA Care Sheets dated 2/11/11, for Resident E indicated the resident was to have a personal alarm on the wheelchair and the bed.

Review of the nurses' notes on 2/14/11 at 11:00 a.m., indicated at 3:30 p.m. on 2/12/11, the CNA reported to the nursing staff that the resident was found on the floor next to the bed. The resident was noted to have left upper forehead laceration 2 cm. (centimeter) by 2.5 cm, left forehead above the evebrow laceration 1 cm, by .3 cm, left lateral side of head, 3.4 cm. by .8 cm., left lateral head laceration 3.5 cm. by 3.2 cm, skin tear to left lateral leg below knee 3.6 cm by 2.7 cm, and a skin tear to the left shoulder blade 4 cm. by 2.5 cm. The nursing staff applied steri strips and sent the resident to the hospital. She returned to the facility with the steri strips in place and area care

Step Four: The QA&A Committee will monitor for any trends monthly for 180 days and will determine the need for any further and/or ongoing monitoring.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

<u> </u>	10 I OI THE DIONIL	- a MEDIONID CENTION	$\overline{}$				<u> </u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	]` "	MULTIPLE JILDING	E CONSTRUCTION	(X3) DATE COMP	PLETED
		155136	a wii	NG		02	C <u>/14/2011</u>
	PROVIDER OR SUPPLIER N LIVING CENTER-FO	DUNTAINVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVENUE LA PORTE, IN 46350				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Continued From parorders.  Interview on 2/14/1	age 3	F	282			
	indicated the CNA responsible for the resident's care on 2/12/11 was off the unit when the resident was found on the floor. She further indicated the CNA had told her that she had not attached the personal alarm when she put the resident to bed that afternoon.		··				
	This federal tag rela IN00084888.	This federal tag relates to complaint number IN00084888.					•
F 323 SS=D			F:	323			
	environment remain as is possible; and	nsure that the resident ns as free of accident hazards each resident receives ion and assistance devices to			F 323: Step One: Applied the personal ala:	orm for	3/16/2011
	by: Based on observation reviews, the facility is identified intervention resident who had fair multiple lacerations was sent to the hospitalian and the sent to the hospitalian and the sent to the hospitalian and the sent to the sent	NT is not met as evidenced ions, interviews and record failed to implement previously ons to prevent falls for a alien out of bed, sustained to the head and shoulder and spital for evaluation. This ffected 1 of 3 residents who mple of 5.			Resident E per the plan of The CNA assigned to the resident's care was re-educed regarding alarm applicated.  Step Two: All residents with current alarm utilization were visinspected to ensure appropriate placement of alarms. No deficiencies were noted.	of care. lucated tion.  at isually opriate	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS	FUR MEDICARI	E & MEDICHID SEKAIDES			(01112)110	1 0000 000 1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED C 02/14/2011	
		155136		NG		
	IVING CENTER-FO	DUNTAINVIEW TERRACE		STREET ADDRESS, CITY, STATE, ZII 1900 ANDREW AVENUE LA PORTE, IN 46350	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(XSI COMPLETION DATE
		<del></del>			-	

## F 323 Continued From page 4

Findings include:

Interview on 2/14/11 at 9:30 a.m., with the Assistant Director of Nursing (ADON) indicated Resident E had fallen over the weekend and had been sent to the hospital for evaluation.

Observation on 2/14/11 at 10:00 a.m., indicated Resident E was seated in a wheelchair across from the nurses' station. The left side of the resident's forehead was bandaged, a dark discoloration was noted under her left eye, and steri- strips were noted behind her left ear. Her left wrist was also covered with a bandage. A chair alarm was in place.

Review of the clinical record of Resident E on 2/14/11 at 10:45 a.m., indicated the diagnoses included, but were not limited to depressive disorder, lack of coordination, anorexia and abnormal involuntary movements. The resident had orders signed by the physician with an original date of 6/18/10, for a personal alarm to bed with safety clip and check every shift and a personal alarm to wheelchair, activate every shift.

The quarterly minimum data set (MDS) assessment, dated 11/18/10, indicated the resident required assistance in all areas of daily living. She was coded as not being steady in moving from a seated to standing position, walking, turning around and moving on and off the toilet.

The fall risk assessment dated 12/19/10, indicated the score was 10. A total score of 10 or above deemed the resident at risk for falls.

The plan of care dated 6/10/10, identified the

F 323

Step Three:

All Nursing Staff were reeducated regarding alarm utilization and appropriate placement per plan of care. DNS and/or designee will conduct visual observations of alarm placement on 5 random residents daily and report any trends to the QA&A Committee for 180 days.

Step Four:
The QA&A Committee will
monitor for any trends monthly
for 180 days and will
determine the need for any
further and/or ongoing
monitoring.

Random avolits will occar across all strifts and days of week. Ju 2/10/17 per helmin DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		155136	B WIN			02	C /14/2011
	PROVIDER OR SUPPLIER	DUNTAINVIEW TERRACE		190	ET ADDRESS, CITY, STATE, ZIP CODE DO ANDREW AVENUE A PORTE, IN 46350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	<del>-</del>		323		····	
	mobility. The appro- limited to: nonskid s personal alarm to b	sk for falls related to decreased baches included, but were not strips on floor next to bed, bed with safety snap, personal air with safety snap and foam oured edges.					·
	Resident E indicate	eets dated 2/11/11, for ed the resident was to have a the wheelchair and the bed.					:
	Review of the nurse a,m., indicated at 3 reported to the nurse found on the floor nurse was noted to have I 2 cm. (centimeter) If the eyebrow laceratiside of head, 3.4 cm laceration 3.5 cm. In lateral leg below known that the left of cm. The nursing state resident to the facility with the steriorders.	des' notes on 2/14/11 at 11:00 B:30 p.m. on 2/12/11, the CNA sing staff that the resident was next to the bed. The resident left upper forehead laceration by 2.5 cm, left forehead above ation 1 cm. by .3 cm, left lateral m. by .8 cm., left lateral head by 3.2 cm, skin tear to left nee 3.6 cm. by 2.7 cm. and a shoulder blade 4 cm. by 2.5 taff applied steri strips and sent hospital. She returned to the fi strips in place and area care					· · · · · · · · · · · · · · · · · · ·
	indicated the CNA r care on 2/12/11 was was found on the flo CNA had told her th	1 at 2:30 p.m., with the ADON responsible for the resident's as off the unit when the resident loor. She further indicated the hat she had not attached the en she put the resident to bed					
	This federal tag rela	ates to complaint number					
	3,1-45(a)(2)						

PRINTED: 02/18/2011

		E & MEDICAID SERVICES					M APPROVED D. 0938-03 <u>91</u>	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A BUILDING			SURVEY LETED	
		155136	e, wi	NG	SQ-7-1114	02/	C /1 <b>4/2011</b>	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVENUE LA PORTE, IN 46350				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			FIX G	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
					·			
				٠				
	•							
							:	